Indiana State Department of Health

B. WING	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED		
STREET ADDRESS, CITY, STATE, ZIP CODE 329 W RAINBOW DR							08/	08/02/2012	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) R 000 INITIAL COMMENTS This visit was for a State Residential Licensure Survey. Survey Dates: August 1, 2, 2012 Facility Number: 011555 Provider Number: 011555 AIM Number: N/A Survey Team: Tammy Alley RN Toni Maley BSW Census Bed Type: Residential: 62 Total: 62 Total: 62 Sample: 7 Primrose Retirement Community of Kokomo was found to be in compliance with 410 IAC 16.2 in regard to the State Residential Licensure Survey. Quality review completed 8/2/12	NAME OF PROVIDER OR SUPPLIER S DRIMPOSE PETIPEMENT COMMUNITY OF KOKOMO			329 W RAIN	TREET ADDRESS, CITY, STATE, ZIP CODE 329 W RAINBOW DR				
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	R 000	This visit was for a Si Survey. Survey Dates: August Facility Number: 011 Provider Number: 01 AIM Number: N/A Survey Team: Tammy Alley RN Toni Maley BSW Census Bed Type: Residential: 62 Total: 62 Census Payor Type: Other: 62 Total: 62 Sample: 7 Primrose Retirement found to be in compli regard to the State R Quality review compl	tate Residential Licensors st 1, 2, 2012 555 11555 Community of Kokomo ance with 410 IAC 16.2 esidential Licensure Su	o was	R 000				

Indiana State Department of Health

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE